UTAH MEDICAID NURSING FACILITY
State Fiscal Year 2017
QUALITY IMPROVEMENT INCENTIVE (2)(xii) APPLICATION
Patient Dignity Devices, Rule R414-504-4

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2017

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

- ☐ This facility has purchased new patient dignity devices, which must be one or more of the following:
  - ☐ Bladder scanner.
  - ☐ Bariatric scale capable of weighing patients up to 600 pounds.
- ☐ A detailed description of the patient dignity devices is attached.
- ☐ The patient life enhancing devices were purchased by May 31, 2017.
- ☐ The patient life enhancing devices were installed between July 1, 2015 and May 31, 2017.
- ☐ Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc. Check amounts must match receipt and invoice amounts. If the check does not match the receipt or invoice amount, an itemized list of invoices paid by the check must be provided with one entry matching the amount of the receipt or invoice for which the facility is seeking incentive payments.

Qualifying facilities may receive up to $100 per Medicaid Certified bed under this incentive (count as of 7/1/2016). This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is $589.94 per Medicaid Certified bed (count as of 7/1/2016).

Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures.

Total Reimbursement Requested (should match spreadsheet): $_____

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.

By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify. Fax to: 801-237-0788 <or> Mail instructions: http://health.utah.gov/medicaid/stplan/longtermcare.htm